By examination per vaginam, I found the uterus in its proper place, with the os tincæ dilated to the size of a shilling, but no discharge. Opiates were given to allay the pain, and an enema was ordered. I called again at 3 o'clock next morning, and found her growing worse. Her pain was even more violent than when I had left her; her breathing now was painful and difficult, as well as hurried; pulse imperceptible; had vomited once since my former visit, and her skin continued cold and perspiring. Large doses of morphia were now given at intervals of twenty minutes, which apparently afforded her some relief. At 4½ o'clock she turned on her right side for the first time, and fifteen minutes afterwards was a corpse.

A *post-mortem* examination was made by Dr. L. Quick and myself, nine hours after death. Having carefully dissected the anterior parietes of the abdomen, we found its peritoneum lining without any appearance of inflammation. Dividing the membrane, the abdomen was found entirely filled with blood and bloody serum, the clots of blood filling the interstices of the viscera. After about three pints of blood were removed, the omentum was seen to be somewhat injected. Removing the clotted blood from the pelvis, the fœtus, with the membranes perfect, was seen floating immediately above the uterus. Pushing this aside, a large tumour presented itself in the right pelvic region, which proved to be the enlarged Fallopian tube, which had contained and nourished the fœtus up to the time of its bursting.

The walls of the tumour, which was very vascular, on one side were thick and strong, on the other thin and extenuated. The ovarium of the right side was somewhat enlarged, and the tubes apparently elongated. The obstruction occurred in the external half of the tube.

The fœtus was well formed, measuring 8 inches in length when extended, and 3¾ when flexed. The membranes containing the liquor amnii were perfect, and the amount of fluid quite as much as usual at that period of intra-uterine gestation. Judging from the size and formation of the fœtus, as well as from the woman's history of herself, we thought she had gone between three and four months.

The womb, which was larger than the non-gravid womb, was apparently healthy, measuring 4½ inches in length, 3½ in breadth, and 1½ in thickness. The canal of the cervix was filled with a ropy and tenacious fluid, and, by pressure on the womb, it discharged a claret-coloured mucus. The left ovarium and Fallopian tube were unchanged and healthy in appearance.

Phœnixville, *July* 14, 1855.

Art. IX.—*Case of Diaphragmatic Hernia.*—By Chas. W. Chancellor, M. D., Alexandria, Va.

On Monday, Sept. 3d, 1855, I was called to see J. P——, ætat. 6; delicate frame; light complexion; strumous habit. His mother informed me that the boy had been unwell, to her knowledge, from the Friday morning previous, complaining of pain in the left shoulder and side, with occasional vomiting, and had had no evacuation from the bowels since Wednesday, August 29th, for which calomel and oil had been given, and retained without producing any effect. He had taken no food, except a piece of bread, which was immediately ejected. Water could be retained only in small quantities. His appearance at this time was quite natural, with but little expression of suffering; he still complained of pain in the left side, which was slightly increased by pressure under the margin of the ribs of that side; there was no

pain elicited on pressure elsewhere. His abdomen was very much distended and tympanitic throughout its whole extent; skin hot and dry, tongue furred and coated with a light brown deposit; pulse accelerated, but otherwise normal; respiration slightly hurried but easy, no cough, and but little thirst.

On questioning the mother of the boy, she stated, "that on the day previous to his complaining, he had in a scuffle with a play-fellow been thrown across a plank, on the abdomen;" but there was no external evidence of injury. I ordered an active purge, to be followed by a purgative enemata.

Tuesday, Sept. 4th, the enemata had produced quite a large evacuation, but there was no improvement in the general condition, showing that the discharge had come only from that part of the intestinal canal below the point of obstruction. Thinking the case to be one of invagination, I proceeded to treat it *secundum artem*. The countenance daily grew more anxious and dejected, and all the symptoms more aggravated, until death furnished relief. His mental faculties remained unimpaired throughout the disease, and intelligent—I might say precocious—answers were given to questions, until the hour of death, notwithstanding a large amount of opiates had been used to palliate suffering and quiet the stomach, which had become very irritable; but at no time was there stercoraceous vomiting. Nothing was ejected but the articles swallowed, mixed with the mucus of the stomach. About twelve hours before death, which occurred on the 8th of September, nine days from the period of attack, the pulse became slower and softer, and the surface covered with a profuse perspiration: the extremities retained a pleasant temperature.

Having examined all of importance connected with the onset and progress of the case, we will now proceed to the pathological condition furnished by a *post-mortem* examination, which was conducted in the presence of several distinguished professional friends, fifteen hours after death.

The only marked abnormal appearances externally, were a slight general emaciation and great discoloration of the integuments of the abdomen. On opening the cavity of the abdomen, the bowels, viewed *in situ*, as may be inferred from the foregoing, were very much distended. The stomach and liver were in a healthy condition, the latter natural in size and colour, and the gall-bladder well filled with bile. The bloodvessels of the intestines were considerably injected. Continuing our examination, by tracing up the colon from the ileo-cæcal pouch, we discovered that the large intestine was perforated just at the upper part of the angle which it makes in forming the transverse colon. The perforation was about seven-eighths of an inch in length, sufficiently large to permit the escape of the contents of the intestine, which had been poured out into the peritoneal cavity: about two and a half inches to the left of this perforation a knuckle of the transverse colon, and also of the jejunum near its junction with the duodenum, had passed through an artificial opening in the middle of the left leaflet of the diaphragm, and were tightly constricted. The contents of the bowels, finding an obstacle to its progress in every direction, had pushed the diaphragm high up, considerably diminishing the thoracic cavity. The diaphragm was then cut loose from its attachments with the ensiform cartilage and ribs, and the viscera of the thorax exposed. Two or three inches of the colon and jejunum were found to be included within the cavity of the chest in a gangrenous state, and adherent to the inferior lobe of the left lung, which latter was also attached firmly to the upper surface of the diaphragm.

Remarks.—This was a case of unequivocal phrenic hernia, of a very uncommon, if not wholly novel character; for it occurred not at the weak tri-

angular space of the ensiform cartilage, but at a point which in health is the most impervious of the muscular septum—a point not weakened by deficiency of muscular substance, nor perforated by natural openings. Could this hernia then have been the result of congenital weakness or malformation of the part? Could a fall or blow upon the epigastric region, sufficient to rupture this muscle, have been received without producing great, if not fatal concussion of the solar plexus?

Another cause of wonder is, that more disturbance of the respiratory function did not exist, since the left lung and diaphragm generally were so much involved.

ART. X.—*Hydrocele permanently cured by the Injection of Iodine and a Seton combined.* By ISAAC LEFEVER, M. D., of Anderville, Perry Co., Pa.

ON reading an article in relation to operations for hydrocele in the last number of the *Journal*, the following cases were brought to my recollection:—

CASE I.—Was called on in 1847, by a gentleman labouring under hydrocele of the right side of the scrotum. On the 17th of June of that year, I operated by means of a trocar and canula, and removed about ℥x of fluid; immediately thereafter I injected several ounces of port wine and water. In a very short time the fluid again collected, and on the 4th of March, 1848, I performed a second operation. On reflecting on the nature of the case, I concluded that the reason why operations so often fail to effect a cure is because the fluid is not entirely evacuated, and the sides of the sac consequently, from its presence, are prevented from coming completely together; and that if some plan were devised for keeping the orifice open, so as to allow of the escape of the retained fluid, and what little might be formed immediately after the operation, success would more frequently follow the measures adopted. The idea of introducing a seton, after removing the fluid by the trocar, presented itself; but fearing it might not be satisfactory in the end, I operated as follows: The fluid, about ℥vi, was evacuated as before, after which I injected about ℥j tinct. iodini. In a few moments the tincture was allowed to pass out, and I introduced, through the canula, the end of a cord, formed by twisting ten or twelve strands of ordinary linen thread together, and upon which I had made a pretty large knot, into the cavity of the sac. The canula was then withdrawn, and the other end of the cord left hanging out of the orifice. Along this cord there was a little discharge, slight suppuration occurred around it, and after a few days it passed out. Some inflammation ensued, but was easily subdued. A cure followed this operation, as there has been no return of the disease.

CASE II.—In this case, several previous operations had been performed by others, but were not effectual in curing the disease. Twice, if I mistake not, the fluid had been evacuated by the trocar and canula; once the scrotum had been freely incised, and the cavity of the sac exposed; and, I think, the gentleman informed me a tent was also inserted. On the 3d of June, 1848, I operated in the same manner as in the second operation in Case I., removing about ℥viii of fluid. But little inflammation followed, as in the former instance, and a like satisfactory result ensued.